

HARVARD MEDICAL ALUMNI BULLETIN

July / Aug. 1974





Why add Librium® (chlordiazepoxide HCl) to your cardiovascular regimen?

Excessive anxiety in susceptible patients can set in motion a chain of responses which add to the heart's work and thereby increase the possibility of cardiovascular complications. Furthermore, intense anxiety may interfere with effective medical management since some patients, in an attempt to deny their illness, may resist acceptance of necessary medication, dietary restrictions and other therapeutic directives. When counseling and reassurance alone are inadequate to

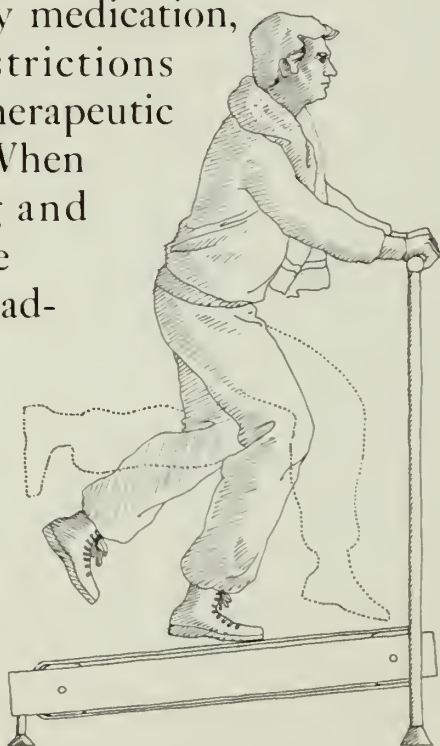


relieve undue anxiety, adjunctive Librium (chlordiazepoxide HCl) may be beneficial.

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wide margin of safety**

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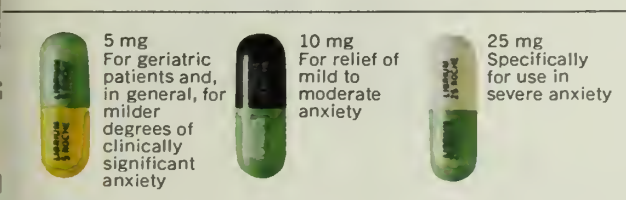
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increasing gradually as needed and tolerated.

Librium is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensive agents, vasodilators and anticoagulants. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and Librium. After anxiety has been reduced to tolerable levels, Librium therapy should be discontinued.



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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or over sedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Overview

HMAA Sets Precedent: Votes Non-HMS Members

By a unanimous vote of the Alumni Council of the Harvard Medical Alumni Association, full-fledged alumni status was bestowed on three Harvard College graduates on May 29, 1974.

In establishing this precedent, the Council sought to appropriately salute the extraordinary dedication and unceasing concern these three men have shown towards the goals and aspirations of Harvard Medical School. As a result of the Alumni Council's decision, the following citation was read and endorsed by the assemblage gathered for Alumni Day, May 31, 1974.

"In recognition and appreciation of devoted and selfless service to the welfare of Harvard Medical School, the Alumni Council voted on May 29, 1974 to confer membership in the Harvard Medical Alumni Association on three distinguished sons of Harvard College: Mr. George G. Walker, a member of the Harvard College Class of 1924; Mr. Donald Bush and Mr. Ridley Watts, both of the Class of 1923.

"Since 1960, when they accepted Dean Berry's invitation to participate in the direction of the Program for Harvard Medicine, each has given continuously and unstintingly of his time, counsel, and personal resources to the complex task of assuring the financial strength of Harvard Medical School. The initiative of the Program for Harvard Medicine, under the leadership of Mr. Watts as general chairman, has been sustained by Mr. Walker as co-chairman of the Committee on Resources, formed in 1966. The individual commitment to the preservation of excellence in medical education, research, and patient care, which they have so ably demonstrated with the effective support of Mr. Bush as a member both of the National Committee of the Program for Harvard

Medicine and the Committee on Resources, is an example to all who cherish the rich traditions of the past and a dedication to a higher order of scholarship and service in the future. Their contributions are especially inspiring to their fellow Alumni, and it is, therefore, with gratitude and admiration that the Harvard Medical Alumni Association welcomes these gentlemen to our fellowship."

Alumni Power Lives— Ballot Count Up in '74

The votes have all been tallied, and the results of the Alumni Council election for 1974 can be disclosed. The new office holders are: President-Elect: William McDermott '42; Vice-President: Oglesby Paul '42; Third Pentad 1959-1963: Catherine M. Wilfert '62; Sixth Pentad 1944-1948: E. Langdon Burwell '44; At Large: A. Clifford Barger '43A. Their opponents in this well-matched election were, respectively: Curtis Prout '41; Harold C. Urschel, Jr. '55; Steven B. Shohet '60; Glenn E. Behringer '45; Raymond C. Collins '41.

It is a credit to all Harvard Medical School alumni that such exemplary persons were nominated to fill these important vacancies on the Alumni Council. In making the proverbial choice, winners and losers are inevitable. Yet those who were not elected reflect upon the honor of the HMS Alumni Association because of their high caliber and sincere involvement with HMS, reasons for which they were initially nominated by Council members.

Comparing this year's outcome with the available figures from 1973 and 1972, alumni can take pleasure in observing increasing alumni power. 1972 showed a ballot count of 2,215; the 1973 total was 2,205 but this was inaccurate as many returns were destroyed in the sorter; in

1974 the final number was 2,721. Of these 2,721 ballots received in the Alumni Office by the May 24 deadline, 114 were automatically disqualified because they were returned minus signatures, and 17 were received too late. The following compilation shows the breakdown of votes.

1901-1	1929-46	1951-46
1902-2	1930-45	1952-48
1906-1	1931-34	1953-46
1907-1	1932-30	1954-59
1908-1	1933-47	1955-57
1909-1	1934-44	1956-65
1911-3	1935-38	1957-54
1912-1	1936-48	1958-38
1914-3	1937-42	1959-64
1915-6	1938-42	1960-58
1916-3	1939-46	1961-46
1917-10	1940-46	1962-45
1918-17	1941-59	1963-50
1919-6	1942-63	1964-60
1920-11	1943A-63	1965-51
1921-11	1943B-62	1966-58
1922-18	1944-66	1967-66
1923-18	1945-59	1968-47
1924-28	1946-44	1969-60
1925-20	1947-55	1970-58
1926-23	1948-41	1971-54
1927-28	1949-60	1972-43
1928-45	1950-55	1973-48

After 15 Years— It's Off the Ground

The Affiliated Hospitals Center has taken the long-awaited first step towards its eventual completion. On April 30, 1974, the Massachusetts Public Health Council granted the Certificate-of-Need and on May 6, 1974, it was accepted by the board of governors of the Affiliated Hospitals Center. This mandates construction to begin on the one-hundred-million dollar facility, which will be Boston's most expensive hospital. The Peter Bent Brigham, the Robert B. Brigham, and the Boston Hospital for Women all will be situated within the structure.

The new 18-story building will occupy the present parking area of the Peter Bent Brigham Hospital with additional land purchased from Harvard University and the Children's Hospital Medical Center. The two and one-half acres of land are bounded by the western side of the Peter Bent Brigham Hospital and Francis, Binney, and Shattuck Streets.

It has taken two years of deliberations on the part of scores of individuals to bring the light of day to what will be the most modern medical facility in the Commonwealth of Massachusetts. The Central Planning Committee, composed of the chiefs-of-service and the administrators of the three member hospitals, held frequent meetings to develop the details of the complicated programs and proposals.

The original proposal, submitted for approval April 30, 1973, specified a facility that would house 688 acute general hospital beds, ambulatory care services, and the necessary support services for the three hospitals. In their decision, released exactly a year later, the Public Health Council approved a total of 680 beds, including 640 acute general hospital beds (to be used as determined by the applicant) plus 40 beds for skilled nursing and rehabilitative purposes. At this year's hearing, the PHC also endorsed the agreement between community representatives and the Affiliated Hospitals Center. This agreement involves the relationship of the AHC to the surrounding community and discusses the construction site, primary care services, governance of the AHC, construction of a section of the hospital that will be fronting Francis Street, and other pertinent matters.

Austen '55 Named Churchill Professor

W. Gerald Austen '55, a former student and close friend of the late Edward D. Churchill '20, has been named the first incumbent of the Churchill Professorship in Surgery at Harvard Medical School.

A noted cardiac surgeon, scholar, and investigator, who has made significant contributions in the fields of gastrointestinal surgery, cardiovascular physiology, and chemotherapy, Dr. Austen is chief of general surgical services and head of the department of surgery at the Massachusetts General Hospital.

Dr. Austen was named a Markle Scholar in Academic Medicine at Harvard in

1963, the first surgeon nominated by the University for that honor. He is a former president of the Association of Academic Surgery, the Society of University Surgeons, the Massachusetts Heart Association and the New England Cardiovascular Society. He was



Dr. Austen

recently elected to membership in the American Academy of Arts and Sciences, the only surgeon in the group of 117 chosen in 1974.

The Churchill Professorship Fund was established by Harvard University in 1970 with a generous gift from the Surdna Foundation. In 1971, HMS established the E. D. Churchill Professorship Committee, composed of 40 distinguished surgical colleagues and friends of Dr. Churchill.

Dr. Churchill was John Homans Professor of Surgery at Harvard and chief of general surgical services at the MGH. His contributions to American surgery were extensive, ranging from pioneer work in endocrine disease and surgery of the heart and lungs, to the development of surgical principles of the management of wounded in war, and a study of the changing patterns of medical care appropriate to mature and developing nations. Dr. Churchill developed and established a program for graduate training in surgery widely regarded as a model for the education of surgeons.

Ebert Predicts Trends in Medical Education

Several predictions relative to the financing and regulation of medical education and practice, based on present trends, were offered by Dean Robert H. Ebert in an address he delivered at the annual Health Forum of Blue Cross of Northeast Ohio.

Among his predictions:

- The size and number of medical schools in the nation will stabilize at roughly the present levels;
- Medical school tuitions will continue to rise so that students will pay a larger share of the cost of their medical education;
- There will be a concentration of biomedical research money in fewer institutions and reductions in the use of such funds as a means of supporting medical education;
- There will be continued pressure exerted on medical centers from the community and the federal government to develop comprehensive care programs;
- There will be increased pressure on medicine to increase the proportion of physicians entering those specialties relating to primary care;
- There will be an extension to the recruitment of house staff and staff by hospitals receiving federal funds (whether university affiliated or non-affiliated) for affirmative action programs stressing the consideration of women and minority groups.

Affirmative Action Tackles Recruitment

As part of Harvard Medical School's Affirmative Action Program, Dean Robert H. Ebert has approved the establishment of a small Committee on Faculty Recruitment of Women and Minorities.

Howard Frazier '53 will serve as chairman of the committee. Other members include: Everett Anderson, Ph.D.; Raquel E. Cohen '49; Donald B. Giddon, D.M.D.; Stephen E. Goldfinger, M.D.; Iolanda E. Low '53; Alix Mathieu, M.D.; and Emil R. Unanue, M.D.

The committee was charged with providing assistance to departments and

ad hoc committees seeking and reviewing candidates, and establishing guidelines for seeking and assessing candidates to facilitate the development of a pool of applicants accessible to departments.

"Efforts of departments to consider women and members of minority groups as candidates for position vacancies are limited by difficulties encountered in identifying potential candidates. The traditional inquiry directed to colleagues and professional journals has not been productive in providing leads to minority persons or women," the charge read.

It was pointed out that although professional societies and manpower agencies have been preparing registers of minority and women scientists during the past few years, a good deal of secondary inquiry is required to

evaluate listings and to obtain more detailed information on those registered. Thus, "a centralized effort . . . to keep abreast of national initiatives, to maintain up-to-date registers and to take the first steps to assist a department or committee would be a suitable objective of the Committee on Recruitment."

The committee was not assigned the task of recruiting candidates (except at the request of a department or committee seeking to fill a position) but is viewed more as an instrument for sharpening the inquiry and assisting in the search by identifying the pool of candidates.

PROMOTIONS

Associate Professor

Bengt E. Bjarnagard: radiation therapy at The Joint Center for Radiation Therapy

David J. Cullen: anaesthesia at Massachusetts General Hospital

Vladimir Fencl: physiology in the department of anaesthesia at Peter Bent Brigham Hospital

Hugh D. Niall: medicine

Leslie W. Ottinger '60: surgery at MGH

George S. Richardson '46: surgery at MGH

Associate Clinical Professor

Milton Hodosh: oral pathology

Cornelius E. Sedgwick: surgery

Conger Williams: medicine

Assistant Professor

Donald A. Antonioli: pathology at Beth Israel Hospital

Nelson A. Burstein '65: pathology at BIH

Leo T. Chylack, Jr. '64: ophthalmology

Demetrios G. Lappas: anaesthesia at MGH

Jennifer H. Lavail: neuropathology

John M. Lazarus: medicine at PBBH

Edmund G. Lowrie, Jr.: medicine at PBBH

Peter R. Maroko: medicine at PBBH

Melitta Schachner: neuropathology

William U. Shipley '66: radiation therapy

Michael L. Steer: surgery

Assistant Clinical Professor

Theodore C. Barton: obstetrics and gynecology

John C. Coolidge: psychiatry

George M. Ryan, Jr. '53: obstetrics and gynecology

Kenneth I. Scheer: obstetrics and gynecology

Allan C. Stam, Jr.: medicine

Philip R. Sullivan '57: psychiatry

Clement Yahia '53: obstetrics and gynecology

Principal Research Associate

Montserrat de M. Fencl: obstetrics and gynecology (biochemistry)

Lecturer

Henry C. Ford: biological chemistry

APPOINTMENTS

Associate Professor

Michael L. Shelanski: neuropathology

Assistant Professor

Inese Z. Beitins: pediatrics

Lloyd A. Greene: neuropathology

John L. Kitzmiller: obstetrics and gynecology at The Boston Hospital for Women

H. William Taeusch, Jr.: pediatrics

Alumni Day 1974

Raquel Eidelman Cohen '49 was the moderator for the Alumni Day Program. Part of her introductory comments centered on an anonymous questionnaire filled out by the Class of 1949 that elicited a variety of opinions on two broad subjects of medical importance — national issues and Harvard issues. Dr. Cohen took excerpts highlighting an analysis of the most interesting responses.

What specialty would you go into if you were graduating from HMS today?

After 25 years of living with our initial choices, most of us were satisfied with our professional specialties, and few appeared to desire any change in types of activities.

How do you think primary medical care should be delivered in the U.S. and what are you doing toward this end yourself?

A typical answer was expressed in the following statement: "Modify the present system of private care with regulated medical insurance and federal subsidy. The system could stand some degree of quality regulation."

Another responded: "After experiencing private practice, government-funded health care facilities, and a university-operated health maintenance organization, I am convinced that the most effective, most efficient, and cheapest method is private practice."

What do you think will be the future of the delivery of primary care in your community? Who will be the primary physician and what will be his or her role?

Answers to this question encompassed all levels of optimism and pessimism. One stated, "Can't answer, who will; could answer, who should" to

"God only knows" to

"The primary physician will be a general internist, pediatrician, and family medicine physician, who would refer patients to surgeons, obstetricians, and medical subspecialists when necessary.

The most pessimistic response was: "It will gradually sink into a mire of bureaucratic bungling. Nurses, GPs, and paramedical personnel will then play a screening role, disguised as primary medical care."

How do you feel about physicians becoming actively involved in state and local politics?

Again, positions moved from admonishing doctors not to be "voices in the wilderness. Their time and effort could be spent more productively in professional and family activities" to

"If they are so motivated, they can play an important role in formulating policy" to

"They were men or women and citizens before they were doctors. They have a right, maybe an obligation, to serve their country and community in whatever capacity they choose."

Dr. Cohen



What kind of universal health insurance program would you prefer or encourage?

Answers favored a combined private-public-national mix with federal co-insurance and some type of regulatory system. Strong feeling was expressed for a system that gives the patient a choice. Most were pessimistic about the government delivering health care.

Are you a member of your state medical society or the AMA?

Most of us are affiliated with a state medical society, but about 50% of the class are not AMA members. One classmate said that national organizations "are too reactionary and do not represent my thinking concerning this country's health problems. Moreover, I have been discouraged in any effort to bring their leadership into the 20th century." Also in this vein, another responded: "AMA leadership = dinosaurs."

Dr. Cohen concluded her remarks by highlighting answers to questions pertaining directly to Harvard issues.

What can alumni do to help Harvard Medical School remain a strong private institution?

Financial support emerged as the most meaningful way alumni can help HMS. Many classmates felt that alumni should become more directly involved in the affairs of the School, particularly in the area of admissions by "recruiting and encouraging outstanding students to apply to HMS." As a whole, they vigorously recommended that admissions should be based on excellence, not on factors of sex or race. On a more pessimistic note, one classmate wrote: "In view of trends in government, I wonder if alumni can really effectively do much in the future."

How might the alumni office be of greater service to you?

Communication was most often mentioned by our classmates. Most would like to see the regional programs in operation as soon as possible. In general, alumni want to become involved; they want to be linked to the medical school. All feel that an active alumni association is the best possible means to that end.

$$A^{10} + B^4 + C^7 + E^6 + F^2 + G^3 + H^5 + I^1 + L^3 + M^{10} + N^2 + P^1 + R^2 + S^3 + V^1 = 15,000 \text{ What?}$$

by August G. Swanson '49

Planning, management by objective, and accountability have become the buzz words in medical schools throughout the country. These slogans have not been generated by the institutions *de novo*. From the perspective of my office at 1 Dupont Circle, Washington, D.C., I believe that the institutions are attempting to follow the precepts of perfect planning, exquisite management, and immaculate accountability provided by the example of the present occupant of 1600 Pennsylvania Avenue. Such exemplary leadership is a good thing at a time when our nation has great concerns for improved health services. Medical schools now appear to be more concerned with planning and management than with being accountable for excellence in education, research, and service. The term "management science" has crept into our vocabulary. We have come to believe the reason the nation does not have enough physicians of the right kind in the right place is because the medical schools have been mismanaged and have planned badly. The conversion to belief in management and planning in some of our institutions has reached a level of religious fervor. Planning committees meet and remeet. Documents detailing institutional objectives often account for half of the dean's office xerox budget. Deans are being chosen not because they have reputations as educators but because their curriculum vitae document that they once attended a course in management. A new service industry has arisen. Firms that will study anything for a price have grown like mushrooms from this bed of management manure. For a few thousand dollars and half the faculty's time for six months, these firms will provide a *plan*. The major advantages such plans have over an in-house effort are that the covers are more artistic and the bindings better.

Solving planning problems for medical schools through the application of management science has been my major research endeavor for the last three years. Because I always want my mother to think well of me, I have chosen to reveal the fruits of my research today on this hallowed ground of alma mater on the occasion of the 25th reunion of HMS '49. The mathematical formula, which is the title of my discourse, when solved, will make all previous planning efforts obsolete.

The term "15,000 What?" on the right side of the equation is of particular significance. It represents the number of physicians U.S. medical schools will be graduating in 1978. The term "what?" represents the uncertainty that now exists regarding the characteristics desired in American physicians graduating during the last quarter of this century. This uncertainty term is also used in equations relating to the environment, the Congress, the Executive Branch of government and population studies. "What is wanted" is the prevailing question in this country and the world today.

In a more sophisticated equation, which I am now developing and will report in the *Journal of Medical-Social Uncertainties*, a third term has been added to the right side of the equation. This term is, "for whom." When the implications of that addition to the equation have been fully explored, it is planned to extrapolate further and report in subsequent articles the effect of adding the terms, "where" and "when." Diligent work ultimately should permit asking the question, "What, for whom, where and when?"

My classmates who had the wisdom to restrict their ambitions to being good scientists know that the outcome of any research ultimately depends upon the quality of the question asked. In planning educational experiments for future physicians, it appears reasonable that we should ask, "Physicians with what

characteristics to serve whom; where they will serve; and when we expect them to be ready to serve." A derivative question is, "Who will be served in what type of system, where, and when?" Having asked such clear and complete questions and plugged them into my equation, it should be possible to crank it through a computer and get the answer.

Unfortunately, mathematical integrity requires that we consider the left side of the equation. The derivation of this portion of the equation was reported at length in the *Proceedings of the Association of Bizarre Social Evolution*. However, because the left side of the equation is essential to understanding the directions which American medical education may take at any instant in time, I will review its derivation again in some depth.

In my earlier paper, the numerator of the equation had several more terms. The variables introduced by the additional terms made the equation insoluble. Because the terms in the denominator represented many forces which considered the terms in the numerator of no consequence, I simplified the numerator. Of course, I could have simplified the denominator by eliminating those terms that made the eliminated terms in the numerator inconsequential. But then I would not have had the paper accepted by the Association of Bizarre Social Evolution. Because I would rather publish than perish, I found this accommodation personally justifiable.

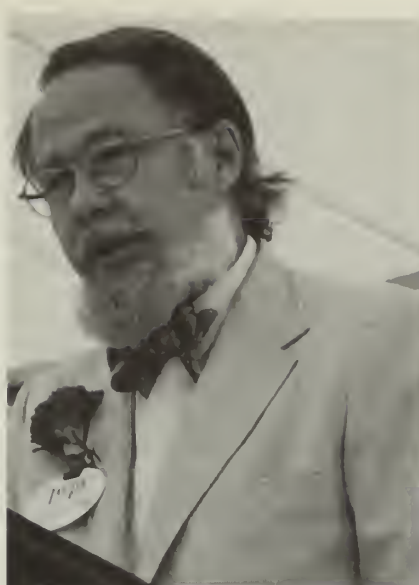
Now to explain the numerator. The figure 115 represents the number of medical schools existing in the United States when this paper was written. An inflator factor of .01 per fortnight has been promulgated by the Office of Educational Pollution. Using this factor, there now may be 116.5 medical schools in the United States. However, studies by the Bureau of Haphazard Resources Development have demonstrated that a straight-line application of

the Office of Educational Pollution's inflator factor over short periods is hazardous. But, Bureau studies uphold the value of the inflator if it is utilized over an extended period. Therefore, I can safely predict that the number 115, if multiplied by .01, and further multiplied by 12 will yield a reasonable estimate which states we can expect 127.8 medical schools being in some stage of operation or development six months from now. Before uncritically accepting this prediction, I must remind my audience that we have not yet explored the denominator of this equation. Wire taps in the research division of the Office of Educational Pollution have established that in developing the inflator factor, several of the terms in the denominator of my equation were neglected. This was an oversight of the same proportions as the one made in another unit of the Executive Branch when it was decided that the American people were children.

The figure 4,607 is the number of graduate programs in medical education in the United States as of this writing. Having probably obfuscated my data by an excessively long and torturous explanation of the inflator factor for medical schools, I hesitate to plunge into a still more lengthy exploration of the titillating tenuousness of this term, but I must.

Residency programs in the United States are solely owned and operated by individuals. These entrepreneurs, usually called "program directors" or "directors," when once granted a franchise may continue to hold that franchise even if a customer has not been through the doors for a year or more. For this reason, the number of operational programs at any point in time is unpredictable. In recent years, enterprising franchise holders have increased their patronage by offering special excursions from exotic foreign lands to students who desire to expand their experience by coming to the United States and working nights. This has created the FMG or Forever Menial Graduate problem.

J. Pol. Scitist reported on the aggressive dynamism of resident recruitment in the *Archives of Inscrutable Planning*. Scitist hypothesized that the number of residency programs remains relatively constant and that the number of pro-



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grams with no residents on duty is balanced by the number of programs with more residents on duty than can be effectively educated and trained. His proof of this hypothesis is both elegant and depressing. The term 4,607 can thus be accepted if it is understood that it stands not for 4,607 residency programs but for 44,858 residents on duty. Scitist also proved that it is impossible to determine the number of residents actually being educated. This proof led to his employment on the staff of the AMA's Council on Health Manpower.

Earlier I explained that in my original work, there were two additional terms in the numerator that had been deleted in order to preserve certain terms in the denominator. One of these was the figure 34,696. That figure represented the full-time faculty of medical schools in the United States. These faculty members were mainly engaged with teaching, research, and other non-productive activities. Many of them were even trying to examine the "what" on the right side of the equation — an endeavor considered to be the sole responsibility and prerogative of the terms in the denominator. Thus, they were eliminated. The other expurgated figure was 401. That was the number of teaching hospitals. Their elimination was principally because of their failure to establish control over the 4,607 program directors. The vulnerability of teaching hospitals was so great that they were cancelled by a strong term in the denominator when their reimbursements for patient services were

suspended by the Social Security Administration because they had more than one societal purpose.

My scientific colleagues are aware that data is a problem. There may be a problem with too little data and there may be a problem with too much data; there may be a problem with irrelevant data; and even at times, relevant data may prove to be a problem. There also may be a problem with too early data and with too late data. My problems with the data used to derive the denominator of the equation fall into the categories of too much and too late. I will explain the too-late problem first.

In competing to gain a place on this program, I wrote the abstract and title before doing the experiment. This I assure you is a commonly accepted and unimpeachable practice. My experiment revealed that the denominator should have had several more terms than the equation shows. Should the editors of the *Bullitania Havardiana Alumni* choose not to accept my corrected paper, I will submit it to the *Compendium of Retracted Abstracts*, thus insuring its retrievability through Medline.

The too-much-data problem required considerable conceptual conniving. Examining the number of terms in the denominator, all seeking to divide the terms in the numerator, I found it necessary to apply Swanson's Law of Sustained Encroachment. This Law states that to be a term in the denominator of any equation derived by Swanson, there must be clear evidence of a sustained and unremitting effort to encroach upon at least one term in the numerator. Through application of Swanson's Law, it was possible to reduce the number of terms in the denominator from over 100 to 20.

Now to explain the derivation of the denominator and thus to make perfectly clear that determining the "what" while mathematically forecastable, is socially unlikely.

The term A¹⁰ refers to the number of A's in the acronyms of those organizations and agencies which are trying to influence the characteristics of medical education in this country. The A's stand for American, Association, Administration or And. Let me illustrate — The

American Medical Association is an outstanding example of Swanson's Law of Sustained Encroachment. It also accounts for two A's and one M. This Association has had both positive and negative effects upon medical education. During the Flexner Era, it was the AMA that facilitated the implementation of Flexner's recommendations. However, the AMA is termed a universal encroacher by encroacher researchers. As its encroachments have multiplied, the ability of the AMA to keep its signals straight has deteriorated to the point that it can make pronouncements that the way to solve the health care problem is to force all those freeloading faculty members to go into practice, simultaneously alleging that the quality of medical education must be carefully preserved. Having an AMA in one's educational denominator is an assurance of never knowing whether you are to be fed or fired.

Two A's are absorbed by the AAMC. For those of you who are medical school faculty members, I must explain that AAMC stands for the Association of American Medical Colleges. Fifteen years ago, this Association would not have passed the test of sustained encroachment. It was largely a boozing society dedicated to holding an annual party where deans could admire each other. Now with its office in Washington, an enlarged membership, and an enlarged staff, the AAMC plays multiple roles in the denominator of medical education. Encroacher scientist, E. N. Croach, has reported that the AAMC can be categorized as a polyvectored encroacher. It has been observed not only to encroach upon terms in the numerator but also upon terms in the denominator. The AAMC is considered pushy and even gauche by some denominator terms who really believe they are the sole participants in the denominator of medical education.

There are other A's absorbed by American and Association but I will pass on to A's for Administration.

"Administration" is a figure of speech of the federal government. Whenever a federal agency has been reduced to a state of utter administrative chaos, it is called an Administration. Thus, we have the Health Resources Administration, the Social Security Administration, and the Veterans Administration. Each

of these administrations is intent upon encroaching on the numerator of medical education. Fortunately, no federal agency is a polyvectored encroacher. In fact, there is a law which states that no employee of any federal agency may know that another federal agency exists. This law is called the Law of Separate Ignorance. Its constitutional basis lies somewhere between the Separation of Powers and Executive Privilege. If this law is ever repealed and federal agencies start vectoring together, the rest of the terms in the denominator will be eliminated.

B⁴ stands for Bureau or Board. Since Bureau is merely a euphemism for Administration, I will progress to the Boards. There are three boards in the denominator. Now board watchers know that there are more than three boards. There are 50 state medical boards; and if today is Friday, there are at least 23 specialty boards. In my equation, the state boards huddle together in a group called the Federation of State Medical Boards. The FSMB barely passed the test of sustained encroachment. Although espousing concerns with medical education, the member boards of the FSMB often solve their problems by certifying anyone who is alive; can by any stretch of the imagination legally be called an M.D.; and will practice in an area of their state where no one else will go.

The specialty boards are represented by the American Board of Medical Specialties. These boards, which are loosely confederated in the ABMS, have been sustained encroachers of magnificent proportions on the second term in the numerator which represents graduate medical education. However, their encroachment has been more concerned with elitism than education.

The third board is the National Board of Medical Examiners. The NBME is what is known as a denying encroacher. While publicly denying that it desires to encroach on any aspect of medical education, it regularly publishes in rank order the success of each medical school's class on its exams. This encroachment-denial tactic is unquestionably effective. Some institutions have been known to change an entire curriculum because their students fell 1/10 of a standard deviation in national standing.

I do not intend to explain the remaining 13 terms. In the course of my investigation, I have identified a phenomenon which simplifies the denominator. This is the Phenomenon of Multiple Hats.

All of the associations, administrations, bureaus, boards and societies in the denominator of medical education tend to choose the same people to serve on planning and study committees charged with determining the "what" on the right side of the equation. Concern for national security does not permit me to release the evidence which will reveal the names of the encroachers in the denominator of my equation, but they are only a handful. They have been granted "encroacher privilege" by the terms in the numerator.

Granting of "encroacher privilege" did not occur deliberately, but was insidiously permitted because the terms in the numerator were not willing to assume control of their own destinies or to take full responsibility for the outcome of their educational endeavors.

How do we solve this planning equation for medical education? If we withdraw "encroacher privilege" from the individuals who have been delegated to encroach by the terms in the denominator, then we reduce the denominator to zero. Dividing a numerator by zero yields infinity. Thus, the opportunity for the medical schools and the residency programs to influence the characteristics of the 15,000 physicians graduated in 1978 would be *infinitely* enhanced.

However, the right to withdraw "encroacher privilege" must be earned. Earning that right requires every institution and every individual in the numerator of medical education to assume responsibility for maintaining excellence while being responsive to the nation's needs. Whether this right can be earned is not forecastable by any technique known to management science; therefore, the outcome of all the planning efforts currently absorbing the energies of medical school deans and faculties may well come to zero. A zero in the numerator of a fraction yields zero. A zero in the numerator of medical education will mean that determining the "what" will remain highly uncertain as regards both quality and quantity.

Caring for Research— Has Medical Education Failed?

by Jay Katz '49

Twenty-five years later I still consider my education at Harvard Medical School a great intellectual experience. I learned much from my teachers and fellow students; both shaped in significant and indelible ways my professional identity. I am grateful for the opportunity to have become a physician in such surroundings. Since I shall be critical, I want you to appreciate that I intend to place only one aspect of my education, though an important one, under the oil immersion lens. In so doing I am not forgetting how much our school has contributed to my professional development; indeed, had I not been so well taught, I might never have been prepared to pursue the ideas that I would like to present to you. As I was struggling with them over the years, I again and again remembered lectures and ward rounds during which we were admonished "to care for patients." But I also remembered a gnawing feeling that I did not learn enough about *how* to care for patients; how not to exploit, in many conscious and unconscious ways, the tremendous authority vested in me.

During our second year at Harvard, the Allied Military Tribunal tried the Nazi physicians who had conducted medical experiments on concentration camp inmates. We heard little, if anything, about this trial throughout our stay at HMS. No lectures or seminars were devoted to an incident in the history of medicine that called for a searching reappraisal of the authority of physicians engaged in research. To be sure, the prosecutor as well as most prosecution witnesses ascribed these experiments solely to the "ravaging inroads of Nazi pseudo-science."¹ But at least some of our investigator-teachers should have known that the concentration camp experiments revealed the presence of an underlying sickness in

the interactions between researchers and their subjects, which had infected the human research enterprise not only in Germany but throughout the world.

Only years later, while auditing a course in criminal law, did I begin to appreciate the full significance of these experiments. "Why," I asked myself, "are not medical rather than law students the first to ponder the rights of investigators and subjects in research?" Other thoughts took me back to my own research on hypnotic dreams. I had abandoned these investigations sometime before joining the Yale Law School faculty because of a vague concern over the increasing evidence of disturbed emotional reactions in my research subjects. They did not complain, and for a while neither did I. On reflection, I was troubled that I had not become concerned sooner. I wondered why, before beginning my investigations, I had not been prepared to pose, if only for myself, many questions about my personal and professional obligations toward my subjects. For example, what should I have told them about the psychological stresses which the investigations might induce. What should I have done in order to preclude any exploitation of their research status? Since I had received a good medical education that emphasized caring for patients, I was quite prepared to offer them therapy should the need arise. However, I had not asked myself whether my responsibility "to care" was fulfilled by turning people into unwitting patients when they had not come to me for that purpose.

I began to appreciate that there were significant gaps in my training. I had been encouraged to care for research, but why had I not been taught *how* to care for the subjects of research? I first tried to tell myself that I had been taught

to care for patients and that I should have been able to apply this knowledge to my interactions with research subjects. But I soon realized that my education in patient care had been incomplete or much too one-dimensional. At a minimum, I had not learned to appreciate the dangers inherent in the inequality of status between physician and patient, which can easily lead to an exploitation of this relationship. Here I do not refer to the gross exploitations of overcharging or deceit but rather to the more subtle dangers that can emerge whenever professionals become authoritarian about their clinical judgments and prescriptions. What are the limits of professional authority? There was and is much that I do not know. I had not been taught when to take patients into my medical confidence; when to share my thinking, my certainties and uncertainties, with them; when to ask their opinions about the various treatment modalities, their risks and benefits, which I could employ in the amelioration or cure of existing conditions.

I was unfamiliar with the idea that perhaps patients should become active participants in decisions affecting their medical lives; or that patients should be granted a "right to self-determination," — a right not necessarily invalidated even if their decisions were based on what I considered to be "foolish, unreasonable, and even absurd ideas."² It had not dawned on me how all-embracing medical decision making can become unless one is very careful. Medical judgments are rarely based on medical considerations alone but on philosophical, psychological, religious, economic, social, and interpersonal considerations as well. What indeed constitutes a medical judgment?

I also began to appreciate that the problems with caring for research subjects

begin with caring for patients, not only because the practice of medicine and research in medicine are so inextricably interwoven but also because research physicians start their training in clinical settings that decisively shape subsequent interactions with patient-subjects. Thus the temptation is great to make "patients" out of research subjects, to forget that their status as patients has been significantly altered by becoming subjects of research, and to treat them with the unquestioned authority that traditionally has governed the physician-patient relationship. Both therapeutic and research practices suffer from the prevailing standard of uninformed consent.

Two years ago when I served as a member of the Tuskegee Syphilis Study Ad Hoc Advisory Panel, appointed by the Assistant Secretary for Health of HEW, the issue of informed consent loomed large once again. The Tuskegee experiment was designed to study the natural history of untreated syphilis in four hundred black subjects. After studying the evidence, there was no question in my mind that their consent to participate had not been obtained; instead, they had been exploited, manipulated and deceived. And, incidentally, the conduct of this study was not affected by the Nuremberg trials, and continued until terminated at the recommendation of our Panel in 1972, although the medical profession had endorsed the Nurem-

berg Code or one of its variants. In a concurring opinion to the majority's finding that the conduct of the study was "ethically unjustified," I particularly emphasized that "the most fundamental reason for condemning the Tuskegee study at its inception and throughout its continuation was not that all the subjects should have been treated, for some might not have wished to be treated, but rather that they were never fairly consulted about the research project, its consequence for them, and the alternatives available to them."³ The threshold issue was neither the risks of participation, nor the unavailability of anti-syphilitic treatment to poor Blacks, nor the hazards of the treatments employed in pre-penicillin days, nor the possibility that treatment might no longer be of benefit to the subjects, nor the importance of the research; all advanced as justifications for or against the study. The real problem was the absence of full disclosure to the subjects of what the investigators intended to do with them.

Another issue troubled me even more. I noted with regret that "the medical profession, through its national association, its many individual societies, and its journals, had on the whole not reacted to this study except by ignoring it. One lengthy editorial appeared in the October 1972 issue of the *Southern Medical Journal* which exonerated the study and chastized the 'irresponsible press' for bringing it to publication.

"When will we take seriously," I asked, "our responsibilities, particularly to the disadvantaged in our midst who so consistently throughout history have been the first to be selected for human research?"⁴

The responsibility for the lack of attention given this question must also be laid at the doorsteps of medical schools. They had not prepared physician-investigators for the complex obligations entailed in caring for research and its subjects, be they patients or volunteers. The focus of such an education requires much more than an analysis of the most dramatic transgressions in research. They only represent the tip of the iceberg, all too easily dismissed as aberrations, as indeed they are. Aberrations, even in the best of all possible worlds, can never be completely eradicated. Needed instead is what our teacher Henry K. Beecher '32 tried to do, though it must be done in much greater depth; namely, to study the human research process relentlessly through example after example of what transpires in everyday research practice. Are not medical schools the appropriate place for this educational and scholarly task?

Many leads must be pursued in an analysis of the human experimentation process. I shall briefly explore two of them — the weight to be given to the subject's right to self-determination and to science's right to freedom of inquiry. Again let me note that I shall freely move back and forth between research and therapeutic considerations. "Thoroughgoing self-determination," as judges have increasingly pointed out,⁵ is the jurisprudential principle on which the legal doctrine of informed consent rests. Ultimately, I believe, the further development of this doctrine will be shaped by the construction which law and the professions give to self-determination. Though judges have invoked the principle of self-determination, it is not at all clear how they wish to see it applied in medical practice or research. Its implications for the physician-patient and investigator-subject relationships require careful delineation, and until this happens informed consent will remain the vague doctrine it is today. Fidelity to self-determination could require a radical shift in these relationships, from one in which the patient-subject is expected to

Claude Welch '32, past president of HMAA



It is probably fortunate that systems of education are constantly under the fire of general criticism, for if education were left solely in the hands of teachers the chances are good that it would soon deteriorate. Medical education, however, is less likely to suffer from such stagnation, for whenever the lay public stops criticizing the type of modern doctor, the medical profession itself may be counted on to stir up the stagnant pool and cleanse it of its sedimentary deposit.

Francis Peabody, *The Care of the Patient*. JAMA, Vol. 88: 877 (1927).



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follow doctors orders to one in which the physician-investigator and patient-subject mutually and fully participate in the medical (research) decision-making process. Self-determination could also be grounded in the historical view of the physician-patient relationship as one of inherently unequal status, because of the discrepancy in skills. If this were to happen, law and medicine would have to specify the duties and obligations of physician-investigator and patient-subject toward one another to minimize exploitation of their inequalities.

At present a patient-subject's right to self-determination, however defined, if not totally foreign to medical thinking, clearly has not received much attention by physicians. Neither the Hippocratic Oath nor the Code of Ethics of the American Medical Association even allude to such a right. Thus, throughout history the role of the patient as a participant in medical decision-making has not been examined in any depth beyond the oft-made assertion that it is an extremely limited one.

In a recent series of seminars with senior medical students, a month away from taking the Hippocratic Oath, they all asserted that patients must be viewed as children who have had little or no capacity to make decisions about their medical lives. I did not view the students' apodictic assertions as an indictment of them because I was quickly able to jar "the cakes of custom" in at

least a few, but as an indictment of their prior medical education. They had been taught all too unquestioningly to strip patients of their capacity to make decisions for themselves. In so doing they, as we, could not learn much about the specific conditions in which such capacities are reduced; or, more importantly, how to nurture and address the patients' autonomous functions which have remained unaffected by their anxieties over being sick. The emerging literature on the treatment of women, the way in which their uteri and ovaries have been assaulted by men-surgeons, also illustrates how the treatment of patients as children (who should be seen but not heard) affects medical decision-making.

Lest I be misunderstood, I do not wish to suggest that physicians do not bring a tremendous dedication to the physical welfare of their patients and that patients have not benefited greatly from this devotion. I only wish to assert that in the process we have tended to impose on patients, however unwittingly, personal rather than medical value preferences about one form of treatment rather than another, about treatment rather non-treatment. Indeed, we often seem to lose sight of the tremendous uncertainties inherent in most therapeutic interventions and, instead, to address our patients with greater certainty than is warranted. It is easier to behave this way when we dismiss the capacity of our patients to understand anything about medical matters, when

we view them as captive children entrusted to our care. By interacting in this fashion, another problem arises; we become enslaved ourselves. We become the thoughtless victims of our own omniscient rhetoric.

These reactions to patients become transferred to research subjects, particularly since the subjects of medical research usually are patients. We often fail to distinguish between research designed to benefit patients directly or intended perhaps to benefit them sometime in the future, or designed to benefit others. These distinctions, in part, become blurred because the need to advance knowledge does not seem to tolerate such discriminations. Surely in a democratic society scientists should be permitted to pursue their investigations, their curiosity, wherever such may lead. After all, scientific work is an individual's property and must remain free from interference. But the advancement of knowledge which depends on the participation of human subjects raises new and different questions, the most fundamental being: "When may a society, actively or by acquiescence, expose some of its members to harm in order to seek benefits for them, for others, or for society as a whole?"⁶ The need for the advancement of knowledge, however legitimate a claim for the continuation of research, has blinded scientists from sufficiently considering the impact their dedicated efforts and personal ambitions have on the lives of their subjects.

I would like to propose that the claims of science and "progress" be assigned a lower value preference than the human rights of the individual. A thoroughgoing commitment to such an ordering of values will have many consequences. I will only mention one: Investigators, in their quest to advance knowledge, will be forced to inquire how the claims of science can be protected without simultaneously undermining human rights. They will have to learn to communicate better with their research subjects and to select research subjects in conformity with the utmost protection of their rights. It could lead to policies that would emphasize a subject's capacity "to make meaningful choices" as a criterion for participation in research, and to procedures which safeguard this principle by selecting for research at least a greater number of the most competent and more advantaged members of society. This would reverse the all too common practice of choosing the least competent and least advantaged instead.

If this ordering of value preferences is accepted, then scientists, and particularly the medical profession, will have to assert that progress is not worth the infliction of indignities on humanity, and that one of the greatest indignities is to treat people as unwilling or unknowing objects, whether of research or of anything else. Scientists would then be obligated to defend this proposition even if faced with the possibility that research will be impeded; for then progress would not rest so much on conquering another disease but on learning first how to treat people with greater respect and dignity.

The scientific community, however, may not wish to agree with my value preference, and this would concern me less if, at the same time, it were willing first to articulate its own preferences and to examine relentlessly their consequences. Otherwise ignorance, rather than reason, will continue to prevail, and science deserves better. Moreover, in giving greater priority to values other than the protection of the rights of human subjects and in examining the consequences of such a position, it will become clearer to what extent human rights must be sacrificed. A conscious acknowledgement of the extent of such neglect in itself will define more clearly its limits. Research sub-

jects deserve at least that much protection.

History has amply taught us how human rights have been trampled on in the name of patriotism, holy wars, and political beliefs. Under the banner of science the same disregard for human rights has already invaded the arena of research, and most dramatically in our generation. Thus, unless we educate ourselves and our students better, there is a real danger that for the sake of knowledge, abuses to individual dignity will continue to be tolerated. Medicine deserves better than to become engulfed by such insidious practices.

I cannot discuss with you today the need for both outside and self-regulations of the human experimentation process. Senate Bill H. R. 7724, introduced by Senator Edward Kennedy, is a thoughtful legislative proposal which deserves our support. Nor do I have the time to discuss with you my disenchantment with codes of ethics. Instead, I have tried to emphasize the need for better education. Ultimately, it will not be through regulations, however necessary in their own right, nor through codes of ethics, so frequently pointed to with pride, but rather through medical education that the research enterprise will be safeguarded, and through medical scholarship that the complex problems raised by modern research practices will be resolved. Perhaps there was once a time when medicine could be guided by the ancient Hippocratic maxim — *primum non nocere* — but today it no longer serves us well. The multiple purpose of medical practice — caring for patients, advancing science, improving the health of the community, nations and future generations — cannot be sorted out by an appeal to this maxim. If we are in need of another golden rule, the Talmudic version is perhaps one of the best. It states: "What is hateful to yourself, do not to your fellow man," but then adds, "This is the whole of the Torah and the rest is but commentary. Go and learn it." It is the learning which I believe is its central message. Alongside of departments of anatomy, physiology, obstetrics, and surgery, we must create a new department of the humanities which will explore and teach what I have touched on today and much more. For far too long a time we have

denied that these problems require intensive study, and assumed instead that somehow we instinctively learn to resolve them. Those of us who will be fortunate enough to attend our fiftieth reunion will be told, I hope, that our great medical school has established such a department or even found a better approach to a systematic and continuing exploration of how to care for the patients and subjects who come into our midst.

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Should (Can) Harvard Educate Primary Care Physicians?

by E. Langdon Burwell '44

Should (or can) Harvard educate primary care physicians? Truly a revolutionary idea, — Harvard physicians actually being trained to take care of *people*! But this is the age of *Future Shock*, requiring sudden adaptation to radical change, so, having recovered from my initial astonishment that this concept should be seriously proposed to such an august audience, I looked for a precedent that might indicate the feasibility of such an undertaking. A classmate, more familiar with the history of this venerable institution than I, reminded me of the pioneering researches of Professor Immanuel Kant Hackett, which culminated in his monumental work entitled "A New Approach to the Psychosocial Dynamics of Heterosexual Relationships."

In his autobiography, Professor Hackett describes how he was inspired to embark upon this new field and how he secured support for his endeavor. (Apparently at this time Professor Hackett was in the habit of keeping tape recordings of his conversations with Important Persons, — a habit which, for some reason, he subsequently abandoned. But thanks to this quirk of fate, we have available his moving personal account, from which I quote.)

"One warm spring evening while working in my laboratory in the basement of the Peter Bent Brigham Hospital doing titanium assays on the hypothalamus of the South African hamster, I was seized with a vague restlessness, one might say *weltschmerz*, — a feeling of uncertainty as to the social relevance of my research. To quiet my thoughts, I went for a walk along the Fenway to the banks of the Charles. Many couples were strolling, lolling or otherwise disporting themselves there on this beautiful spring evening, and I asked myself, 'What does the hypothalamic metabolism of titanium have to do with this basic human activity which seems so important to society?'

"Suddenly the inspiration came to me, — 'Could, or should, Harvard become a center for teaching and research on sex?' Nothing, absolutely nothing, was being done in this field, and yet there was such an apparent need for basic research!

"I returned so excited by this concept that I could scarcely contain myself and spent the entire night writing out my proposal for the Dean. The next morning I presented it to him, my heart in my mouth with anxiety as to how he would react to this radical departure from the traditional role of HMS."

"A brilliant concept, Kant old fellow!" he said. "I can see it now, 'The I. Kant Hackett Institute for Psychosocial Research in Heterosexual Relationships.' It's high time we got into this sort of thing, you know. Those fellows in Washington just don't seem to understand the importance of basic research anymore, and there is all sorts of money available for research on population problems. I can't seem to remember whether it is overpopulation or underpopulation that concerns them, but no matter. There's *grant money* available, and who, pray tell me, has a record in grantsmanship superior to Harvard? Furthermore," he said with a sly wink, "we might be able to include a sizeable grant for your studies on the hypothalamus of the South African hamster."

The Dean warmed to the subject, and I was amazed by his immediate grasp of all the implications. "We will need a coordinating committee with representatives from all the teaching hospitals; they'll want to get in on this, you know."

"Do you think Franny will give us any difficulty?" I interjected.

"Why, Franny's not against sex!" he said.

"No, but he will want to *organize* it, and have everyone do it *his* way," I replied.

"Don't worry about difficulties," he said. "At Harvard we thrive on difficulties. When we don't have enough, we create them! What we need," he went on, "is a totally new concept, a unique Harvard program and . . . I have it!", he exclaimed, "an SMO!"

"What's an SMO?" I asked.

"A Satisfaction Maintenance Organization," he replied. "Pre-paid group practice with built-in quality and cost control. We'll do away with solo practice, fee for service, and all the inefficient features of the present system!"

"Like the Arabian harems!" I chimed in. Then, with some misgiving, I added, "But that is not exactly a new idea, and it hasn't really caught on in other parts of the world."

For the first time he frowned. "Kant, old fellow," he said, "this is no time for timid thinking! It's true, we'll need front-end money, but we have friends in Washington who can supply that. And I think we can have the laws written so as to make SMOs practically *mandatory*!"

"What about the students?" I said. "Some of them may feel they have more experience in this field than the faculty." "Humbug," he replied. "Nothing but random unplanned experimentation! No computer simulation models, no double blind studies, nothing really scientific! Which leads us to the question of recruiting faculty," he went on. "I'm sure we will have some frivolous suggestions such as inviting Zsa Zsa Gabor or Hugh Hefner as visiting lecturers, but we must have a faculty with impeccable credentials and solid training in basic research, uncontaminated by any so-called 'practical experience' in the field. After all, we must carry on the Harvard tradition!"

The Dean proceeded in a masterly fashion to overcome every problem I could foresee, and from that moment on, I knew that the course of my life work had been charted."

Taking inspiration from the trail-blazing efforts of Professor Hackett, I would say that the answer to both questions is yes. Harvard can, and should, teach primary care physicians. John Gardner, formerly Secretary of HEW and initiator of Common Cause, has remarked that

"A society which gives much higher status to its philosophers than to its plumbers will soon find that neither its philosophy nor its plumbing hold water." I believe that a society which commits the same error with regard to medical research and teaching as contrasted with medical practice will soon find that its research and teaching are not relevant, and the quality of care given by its practicing physicians is inferior. Future biophysicists, clinical professors, and practitioners pursuing undergraduate medical education together would all benefit.

Students, initially enthusiastic about family practice on entering medical school today, claim that "the system wears them down," and by graduation many have shifted their interest to specialty practice, teaching, or research. This may be an euphemistic statement of their gradual realization that at present the specialist enjoys more regular working hours, higher income, and higher social status than the primary care physician. It is hypocritical of us, their elders, to berate them for not having the courage of their convictions, while we do little or nothing to alter the factors that affect their choices.

In order to put the problem of primary care in some historical perspective, I would like to suggest that the delivery of medical care in this country may be divided roughly into four phases:

The *first phase* can be designated as the "pre-scientific period," prior to the end of the 19th century, when, as Professor L. J. Henderson put it, "a patient visiting a physician had roughly a 50% chance of benefiting from the encounter." Physicians were widely distributed, both in large cities and small villages and almost all involved in the delivery of primary care. While the diagnostic skill of physicians might vary considerably, the therapy available was extremely limited and therefore fairly uniform in quality.

The *second phase* was characterized by the application of the scientific method to medical practice. "Centers of excellence" developed around medical schools such as Johns Hopkins, Harvard, Columbia, etc. and the great private clinics (Mayo, Crile, Lahey, Ochsner, etc.). The rapid development of diagnostic and therapeutic skills and

medical technology produced marked variation in the quality of medical care available, and patients with serious medical problems and adequate means generally made their way to these centers. This phase lasted roughly from the start of the century to World War II.

The *third phase*, beginning after World War II, lasted until roughly 1970. It was characterized by an increasing trend toward specialization, vastly increased expenditures for research, and by the proliferation of community hospitals aided by the Hill-Burton Act. At the same time, the upgrading of all hospitals by the JCAH and the migration of well-trained younger specialists to medium- and small-sized community hospitals increased the quality of care available in these hospitals. While there was an aggregation of physicians around the community hospitals, the areas in between were gradually depleted of physicians; the older general practitioners died off and small communities and economically depressed areas became less well served medically than they had been before. The changing ratio of primary care physicians to specialists in favor of the latter further aggravated the plight of the patient looking for help with everyday medical problems. Nor was the patient placated by statements that the quality of care available in this country was the highest in the world. Criticism of the health care delivery system became increasingly strident, and it appeared that we were experiencing famine in the midst of plenty.

The *fourth phase*, which I believe we are just entering, will be characterized by a renaissance of primary medical care:

- integrated with the community hospitals and large medical centers but available conveniently to the patient's home;
- personalized to suit the patient's emotional needs;
- financed so that everyone can afford a basic level of good medical care;
- backed up by an administrative "infrastructure" that will provide a built-in quality and cost control mechanism, a capacity for continuing education, and which will relieve primary physicians of many of the "business" aspects of medical practice, allowing doctors to concentrate their efforts on the care of patients.

The demands of society and the increasing interest of medical students in primary patient care assure this outcome, but just how it is to be accomplished is a matter of present debate.

Various proposals have been put forth, such as the development of pre-paid group practice (HMOs) either "non-profit" with government subsidy or by "for-profit" corporations; the development of area "health care corporations," which would provide area-wide management of the health care delivery system; and the development of "out-reach" satellite clinics by hospitals. Some of us are developing an alternative approach to the delivery of primary medical care in small communities which we feel would be readily acceptable to patients and physicians, flexible for adaptation to local needs, easily financed without requirements for government subsidy, and adaptable to monitoring for quality and cost control. Simply stated this proposal is based on a concept of franchised primary care centers — what might be described as the "MacDonald Hamburger stand approach" to primary care delivery.

It has always seemed strange to me that while no biochemist would have much respect for a colleague who had not spent time in a laboratory, and a professor of clinical medicine could not be an inspiring teacher without having spent many hours on the wards, there are many who represent themselves as experts in the field of primary care delivery who have never had anything to do with the continuing care of patients.

Why has there been a dearth of good teaching of primary care? First, it is true that until recently the more able young physicians tended to go into teaching and research, and the less able went "into practice", so that the "LMD" was considered a second- or third-class citizen by medical students, who usually chose the specialist as the role model to emulate. Second, a good primary care physician is almost always terribly busy and harrassed, and has little time for organized teaching as is customary on the wards at teaching hospitals. Third, even though a rising tide of interest in primary care has developed, the purely logistical problem of getting students out to community hospitals and doctors' offices where most pri-

mary care is delivered has been a difficult one to solve.

You may not all be aware of the SAMA "MECO project" (Medical Education with Community Orientation), which was started in 1969. In 1973, over 600 students were placed in 365 communities around the country, and this summer, over 1,000 were placed in small communities, group practices, neighborhood health centers, Indian reservations, etc. The students usually spend six to eight weeks during the summer between first and second or second and third year of medical school, receiving a small stipend from the community hospital or local medical organization, plus room and board.* Incidentally, one of our classmates, Felix Heimberg '44, has been a preceptor in this program.

Family practice residencies are springing up all over the country, and as of 1974, there were approximately 200 with over 1,000 positions offered. Furthermore, nearly half of the medical schools now include family practice in their curricula.

Each of the medical schools in Massachusetts has embarked on programs to expose students to primary care, and despite the somewhat disparaging remarks about our alma mater at the beginning of this talk, Harvard has made serious efforts in this direction as described in the May-June HMAB. I believe, however, that the new University of Massachusetts Medical School in Worcester is several laps ahead of us in this race at present.

What specifically might Harvard Medical School do if it is seriously to undertake the training of primary care physicians? I would suggest that the following measures be considered:

- A portion of the undergraduate curriculum should be devoted to family practice, community medicine, and medical economics and politics. This might be mandatory the first two years and elective in the third and fourth

* Students or potential preceptors who are interested may contact Mr. James Ehrlich at Boston University Medical School, or Ms. Sandra Smith, SAMA Headquarters, 1400 Hicks Road, Rolling Meadows, Illinois 60008.

years. Undergraduate teaching of primary care should be carried out, so far as possible, in the field rather than the classroom. During the first year, two-week preceptorships with family physicians, group practices, neighborhood health centers, Blue Cross - Blue Shield, PSRO organizations, or working with the staff of a state or federal legislator on health legislation would be followed by seminars during which students compared their experiences.

- Harvard Medical School should develop stronger ties with community hospitals, neighborhood health centers, and practicing physicians in the metropolitan area and beyond, as well as with the governmental and quasi-governmental organizations that regulate and pay for health care, such as Blue Cross - Blue Shield, Commonwealth Institute of Medicine, PSROs, Department of Public Health, etc.

- A family practice residency program, approved by the American Academy of Family Practice, should be established.

- A community hospital of approximately 100 beds should be established within the area of the medical complex surrounding Harvard Medical School. Perhaps a most appropriate solution, when the new affiliated hospital is built, would be to refurbish the core of the old PBBH (lopping off the "pike" and its appendages), and use it as a community hospital. The hospital should be governed by a board of trustees truly representative of the community. Harvard Medical School should provide guidance but not governance. A wise choice of trustees would be necessary to prevent the hospital from becoming a battleground for local political factions, but this could and should be done. The staff would consist of doctors actually practicing in the community. (The OPD might be remodeled to provide physician's offices.) Specialists at the affiliated hospital would be available as consultants but would not control the services at the community hospital.

- The Harvard Community Health Plan should move to a location between this community hospital and the new affiliated hospital, thereby having the option of managing patients in either hospital. The staff of the HCHP should participate in running the community hospital but should not dominate it. It



Dr. Burwell

would be a worthwhile experiment to see whether the doctors in a pre-paid group practice could co-exist with the other physicians not in the group. The competition to deliver the best quality care should stimulate both groups.

- As a corollary, the medical school could use this community hospital and its affiliates to study the problems of health care delivery in a more realistic fashion than has been done in the past. The impact of PSROs and national health insurance on medical practice will be highly interesting topics in the next decade, and such a program would provide a readily accessible model for study.

Elliot Richardson, delivering the Shattuck lecture to the Massachusetts Medical Society recently, made a strong plea for preservation of this sort of medical practice in a society adapting to rapid technological and political change. Great teachers of medicine, among them, Sir William Osler, Sir James MacKenzie and Dr. Francis Peabody, have made the same point that the essence of patient care is caring for the patient. If this gentle art is trampled underfoot in our mad rush to organize, finance, and regulate health care delivery, we will have indeed won a Pyrrhic victory.

HMS has pioneered in many areas to promote the health and well-being of humankind. I am sure it will not lack the talent, imagination, and personal commitment to meet the present challenge.

A Majority Report

by Alvin F. Poussaint

Associate Dean for Student Affairs, HMS

One of the important issues in considering programs for minority group students and for other people, who have been out of the mainstream of society, is that we have not come far enough to achieve the type of society that really gives equal opportunity to all people. And in this situation it is difficult to judge what is fair and what is equitable in terms of the entire population.

Until 1967, most of the hospitals in the South were segregated facilities. Segregated health facilities meant that black patients actually did not receive proper care. They got the old equipment; the rusty needles; the wards in the basement. The medical profession was not a leader in eliminating segregation in health facilities. Only in 1966 did many black physicians for the first time, gain admittance to the AMA and local medical societies in the United States. Finally, around 1966-1967, medical schools in Southern states began to open their doors to black applicants; previously, black students were given scholarships to attend medical schools elsewhere. Such extreme legalized oppression and deprivation has had a profound psychological affect on the black community.

The educational system has also taught blacks to consider themselves inferior. Most of the black schools in the South were not autonomously controlled; they were run by state officials, generally white, who had certain types of attitudes. Many of these institutions were not programmed to be good schools. How can such a discriminatory system be made equitable? We frequently use the term cultural deprivation more as a euphemism, to conveniently deal with the problem. I think it is of greater importance to fairly evaluate intellect, potential, and ability.

Are test scores valid instruments to measure ability? There is much controversy in this area; even the college board people and MCAT administrators acknowledge that these tests are culturally biased. Particularly in the Northeast, some students have been exposed in their educational background to standardized test-taking procedures and usually perform better than their counterparts in other areas of the country who have never encountered that type of exam. There is also strong evidence correlating proficiency on the MCAT with a specific type of cultural background, generally white middle class. Students do even better when they come from a professional home which emphasizes language and analytical skills. Many of the country's minority group students come from lower socio-economic backgrounds and have not been adequately prepared or advised.

White disadvantaged students also do poorly on standardized examinations and are admitted to Harvard Medical School with lower MCAT scores. Last year, the student with the lowest MCAT verbal score was not a black student, but a foreign student of outstanding ability who just could not do well on this type of exam. In competition with students from the Northeast sector, white students elsewhere consistently perform and score lower.

The validity of test scores as a measurement of ability is at best nebulous. For example, there was a young woman from one of the big seven colleges in New England who applied to HMS with an almost straight A average, but her MCATs were all below four hundred. We could not explain that. Obviously, her academic record was more significant than her MCAT scores.

The audience listens attentively as



“... extreme legalized oppression and deprivation has had a profound psychological affect on the black community.”

She came from a low-income background in a rural area and somehow she did not click with those types of examinations. We have admitted students with good academic records from lesser-known institutions. Frequently, their MCAT scores do not match their cumulative records. Is the MCAT that biased? In our estimation, low MCATs seem to indicate the student has not had a great deal of experience with the use and manipulation of language. Because MCATs do not show intellectual ability per se, we try to concentrate on a student's academic performance and select applicants who have performed well in their college work, no matter where that college may be. We want to look at the entire spectrum of the student's record and recommendations in an attempt to assess the total picture. Regardless of cultural or socioeconomic circumstances, if a student has performed well, then we must allow

each individual to stand in a competitive position with others who apply to HMS.

One of the pitfalls in choosing people from non-traditional backgrounds is that they will probably experience a degree of culture shock getting adjusted to a new environment. Harvard has several ways to aid students during the transition period. There is an optional summer support program which invites accepted students to come to Boston, take courses and become familiar with HMS. There is a test service to help students deal with the mechanics and strategies of test-taking. Finally, there is a support system of tutors. Minority group students often act as a barometer for deficiencies in the system. A poor advisory system affects students from different backgrounds; if the advisory system is improved for a specific group then it is improved for everyone.

Right now, unfortunately, the focus is on negative aspects of minority group programs at colleges and other institutions. We tend to dwell on the failures and to overlook successes. Harvard Medical School should be proud of its program; it is a success because standards are not being compromised. In order to graduate, students must pass Part I and Part II of the National Boards, and meet the requirements of the examinations committee. An indication of success is the caliber of internships secured by minority group students. Harvard's minority group students will play a significant role in serving the community. There is no guarantee that they will bring better health services to their particular ethnic groups throughout the country. I think it is a mistake to believe that they should. All physicians — black, white, and Spanish-speaking — have to increase their consciousness to administer to the needs of all people.

In essence, once legal segregation and centuries of oppression are eliminated it is unreasonable to suddenly expect people who have never walked to get up and walk perfectly. It just does not work so simply. We must rethink the term, excellence, to encompass a physician's commitment to society. We might consider the attitude China has taken toward educating physicians. Students are selected and supported at medical school through the auspices of individual communities. The responsibility of the educated physician then, in China, is to return and serve that community. We are definitely light years away from emulating a similar model, but such new approaches to the selection of medical students lead to a range of untapped possibilities for the future of medical education and minority group students.

Dr. Poussaint explains a point.



A Panel Discussion

What It's Been Like

by Marjorie J.K. McKusick '49

What has Harvard meant to me, as a physician, as a member of my community, and as a woman? Certainly being at HMS was an exciting experience. In our class, for the first time, in addition to women, there were many men in the military service or just out of the service, following World War II. They were questioning, seeking answers, challenging the professors in a way I had never experienced. From them I learned that it is never safe to accept didactic teaching with complacency. In order to learn, in order to change yourself or the world around you, you must not just absorb facts like a sponge, but make sure you understand the why, explore alternate solutions to problems, and question any "fact" that is presented without adequate reasons or without sound supporting data. Our professors were challenged, they listened, they responded. In their infinite wisdom, they almost always came back with all the reasons, all the supporting data, all the answers. On those occasions when our professors were at a loss, they would encourage a student to seek alternative answers and find alternate solutions, and thus the laborious process of learning was supported, and not squelched by our teachers.

Although I did absorb a good deal of book learning at Harvard, I was not fully prepared for the real world. Or so I thought, when I was plunged into the emergency ward of a general hospital two weeks after graduation. I had to write a prescription! Not only did I have to write a prescription, it had to be in ounces, drams, or drops! I only knew how to write orders in grams, milliliters or units. I survived this crisis (with the help of an old nurse) and pondered why I had never received any instruction in prescription writing at the mecca. Of course, the answer was clear. It was a waste of time. I learned quickly, as my instructors would have predicted, and soon could write prescriptions at a rate

envied by my peers. This was a technical skill, unworthy of the time or commitment of my professors to teach. What I had learned — how to make a diagnosis — I realized, was much more important. With the constantly changing pharmacopoeia, only a basic understanding of drug usage was really needed in medical school training. Compared to students from other training centers who were taught a shot-gun approach, HMS taught me a methodical, judicious approach to diagnosis. For example, a child comes in with abdominal pain, and after a brief history and physical exam, you order a CBC, a urinalysis and culture, an IVP, a G. I. series, a barium enema, and if you're really knowledgeable, an EEG to rule out abdominal epilepsy! Nine times out of ten, all these studies are normal, and you're stuck with the same problem: stomach aches! In my experience, if you do a more complete history, a thorough physical exam, and spread out your studies over a period of time, by the time you're through, the stomach aches have gone away, with or without a specific diagnosis. Although we received no training in economics, either of office practice or the status of the patient's pocketbook, that approach paid off well in both of these areas. Even before the threat of having to justify hospital admissions to a review board, I often treated patients on an ambulatory basis, while my peers were admitting patients to the hospital for a crash diagnosis.

I moved, then, from training into private practice and met with some resistance from the local pediatricians. "You're a married woman, you'll get pregnant and drop out." or, "Your husband works for du Pont? He'll be transferred before you know it." or, "Why don't you take a job with public health? They need people for well-baby clinics. You could make a good living and not have any responsibility. "I didn't want any of these things. More than anything I

wanted to practice pediatrics so I put out my shingle and have managed to keep it hanging, despite three pregnancies, threats of transfer which never materialized, and persuasive offers in public health. This was "my thing" and I had the training to do it, and do it well.

This is not the end of my story. Harvard has supported me in yet another way, that may be the most meaningful of my life. HMS gave me the courage to stand up for my convictions.

When I moved to Delaware after completing my training in 1953, I had no idea I would be moving to a "Southern state." The Mason-Dixon line passes through Delaware, and as a border state during the Civil War, it left us with many serious and explosive racial problems. There were state laws requiring separate schooling for children, separate toilet facilities in public places, separate areas on buses, and separate restaurants. After living in Boston, New York, and even Philadelphia, that was a real shock! I encountered the racial barrier on my first trip to the Delaware Hospital when I wanted to use the bathroom. I came to a door labelled "Women-White." I assumed that it was reserved for hospital personnel, women in white uniforms. With the haughty pride, that comes from being able to wear street clothes after years of white uniforms, I proceeded to the next door. It said, "Women-Black." I soon realized that we were, indeed, a totally segregated state.

My early efforts at helping to serve the black community started when I elected to work in a black well-baby clinic, in a newly developed housing project on the fringe of the city known as Northeast in 1954. If a white family came in by mistake, they were quickly and quietly referred to the white clinic across the broad avenue, which served the slightly more affluent Italian and Puerto Rican families. The families in the Northeast housing project had been carefully selected from the ghettos of Wilmington. Each family needed a wage-earner, preferably the father, and a stable family unit. Although it was a pleasure to work with these mothers and babies, after 14 years I realized I was seeing a lot of teenage mothers, even some girls 11 and 12 years old,

who were bringing their babies to the clinic. The real shock to me was that these young mothers had been former patients of mine in that same clinic. Somehow, I felt that I had failed, even with a carefully selected clientele. The problem, at any rate, was terribly obvious. Young girls were expelled from school, as soon as their pregnancy was discovered, and forced to remain at home to care for their infants. The vicious cycle of pregnancy, welfare dependency, and neglect was depressing.

This realization came to me at a time in the late sixties when social awareness, racial disputes and welfare dependency were emerging as serious problems throughout the nation. I had no difficulty in organizing a group of concerned professional people in our community. In 1968, Delaware Adolescent Program, Incorporated (DAPI), was born. This agency, through the dedicated efforts of many people, has become a model serving school-age parents throughout the state. It is a comprehensive program that provides all the services needed by young mothers and fathers and their families at one location in each county in the state. It provides on-going education, medical care, social services, and infant day care. The effectiveness of our program is just beginning to show. We have completed a four-year follow-up of the first 100 girls who went through the program, and find that in at least four parameters the program has been highly successful, compared to statistics that we compiled before our program began: the prematurity rate has been reduced; the high school drop out rate is less; repeat pregnancies are fewer; and the number of girls on welfare rolls after four years has markedly decreased.

How does this relate to a Harvard Medical School education? At HMS one gets a feeling of intellectual honesty, a desire to be creative, different perhaps, and quite frankly to do good. I never doubted that I was being trained to help people, whether by direct service or in the research lab; the goal was always the same and crystal clear. Considering the racial bias, the hostile governing bodies, and prejudice in our state, developing a truly service-oriented program in the 60s was a real challenge. About the time DAPI was



From l. to r. Drs. McKusick, Anderson, and Garrison.

suffering a severe financial setback, a picture of several noted Harvard Medical School professors, marching for a social cause, was wired throughout the nation by the Associated Press. It was like a shot in the arm to me and my colleagues. Distinguished men and women were displaying the courage to support their ideas and ideals at the risk of their prestige and possibly their jobs. We could not have been more inspired. By god, if they were willing to stand up publicly for a cause, so could we. We requested an interview with no less than the governor. I am sure my Harvard degree as well as my determination got us past that door and we emerged with the money for DAPI in our pockets.

Hardest of all is to relate my Harvard experience to being a woman. Being in the first class of women graduates admitted to Harvard Medical School has not really given me much mileage. Unfortunately, it now dates me to the dark ages! It does, however, put me in a class of women who considered themselves liberated long before "Women's Lib" became popular. At first, we were repelled by the idea of women's lib, on the basis that we "made it" in a man's world, why couldn't they? But, after a while, I realized maybe they were right; there was a lot of discrimination against women in education, in the job market, in advancement, and even in equal pay for equal work. Having overcome the disgust of bra-less-ness, who's on top, etc., I have come to the decision that

we should support the movement for women's liberation, and all it implies. I think it has made an impact on parental attitudes that allow daughters to consider medicine and other male-dominated professions as careers. It appears to have had considerable impact on the numbers and percentage of women enrolled in medical schools. The traditional model of a young lady becoming a wife, mother and housewife, seems to be dying as an ideal. Other factors, such as our present economy, undoubtedly also play a role. In today's world, it is hard for a family to have a comfortable income, unless both partners of a marriage work. Young women recognize this fact, and are thinking about what kind of work they wish to do, how much time they will have to spend, how they will finance their education, and what sort of lifestyle they hope to support in their adult years. I only try to advise my younger colleagues that there is a price they must be willing to pay. Extra liberty, freedom and benefits require taking the responsibility and dedication that accompanies these rights. Equal opportunity and equal pay mean living up to the job "like a man."

Finally, from a recent article in the *New York Times* reminding us of what life was like back in 1949: "Television was in its infancy. Suburbs had only begun to sprout on the fringes of the nation's great cities. The memories of World War II were fading, and crew cuts, bobbie sox and convertibles were once

again cruising Main Street America. People had not yet heard of Sputnik or the Super Bowl and knew little of faraway places called Seoul, Panmunjom, Saigon and Hanoi. But there was plenty to think about. 'Give-'em hell' Harry Truman, having confounded critics and pollsters, had just been inaugurated and was talking about a 41 billion dollar budget. Communists were lurking around, or so it was said, being vaguely ominous. Rita Hayworth was about to marry Aly Kahn. The Brooklyn Dodgers — 'Dem Bums' — would soon cop the National League Pennant. The average wage was up to \$55/week. All in all, prosperity seemed just around the

corner. Across the 48 states, the modern postwar era was in flower. It was a time of great expectations. It was a year of hope. It was 1949."

Now it is 1974, 25 years later. It is a much different world and, I feel, a better world. Thanks to Harvard Medical School, I have felt very much a part of living in the past 25 years and hope that I have contributed in small measure to the changes that have occurred in my own community. Harvard has given me a superior education, a demanding philosophy, the feeling of self-esteem and worth. In a word, HMS, "You done good by me!"

by Kathryn D. Anderson '64

There are three stages of women in medicine. The first was well characterized by Samuel Johnson who said of a woman preacher, "It is rather like a dog walking on its hind legs, merely doing it at all is remarkable." The second stage is the era of Women's Liberation which, I believe, is passing. Women have drawn attention to themselves in all walks of life and hopefully, most have earned the right to do what they want and to fulfill their own destinies. The third and final stage of women in medicine will be one of assimilation, when it will no longer be remarkable to find women in all its branches. I look forward to the time when this kind of discussion is an anachronism.

Like all surgeons, I have gone through a long, hard, intense, but enjoyable residency. As I look back trying to assess my experience not as a surgical resident, but as a woman surgical resident, it falls into several distinct periods.

During the earliest years of my surgical residency, I found my own inexperience in the operating room frustrating. To quote Judson Randolph, my present chief of surgery, "Surgery isn't hard to do, it is just hard to get to do." And I remember that it was a little harder for me than for my male colleagues. On occasion I felt rather like the Red Queen in *Alice Through the Looking Glass*, who said, "You have to run as hard as you can to stay in the same place." One gets into a vicious cycle — the less experience one has in operating, the less

operating one gets to do and therefore the less experience one acquires. This is a barrier that every surgical resident must break through and I remember quite distinctly the pleasure I experienced when I realized my brain had become connected to my hands.

My residency program in general surgery in Washington, D. C., had rotations through a number of affiliated hospitals around the city as well as in the Main University Hospital. With each new rotation, I had to re-prove myself and to deny by my actions the old saw that women are bound to rely on their femininity to do less work. I believe in the earlier years that this took longer for me than for my male colleagues, but disappeared during the later part of my residency. I am sure that most surgeons would remember with greatest pride and affection their year as chief resident. This is the year when the emphasis changes from primarily a learning experience to primarily a teaching experience, and one assumes greater responsibility for the training of the house staff. I took a chief residency in general surgery and then went on for two further years of training in pediatric surgery. This was when I completely stopped regarding myself as being different. I no longer had to prove myself to my peers or my professors. Proving myself as a teacher to students and junior residents was a challenge with not the slightest overtones of sex. The patient waiting for treatment of a gunshot wound of the pancreas cared not that one of the doctors was six feet two and the other five feet two.

I have been unusually lucky in my choice of husband. His ambition for me is no less, and sometimes I believe, greater than my own. During the down times when I felt that I could just not stand it another minute, he encouraged, cajoled, and bullied me into using my full potential. It is very possible that without him I might have allowed myself to be satisfied with less than my best. At every point in my career, from the time when I was eight years old and announced to my father that I wanted to be a doctor, there have been men who have had a strong enough sense of their own masculinity and intellectuality that they have not been threatened by a woman physician. They have helped me through the good and the bad times. One of the earliest of these was Professor Bernie Davis at HMS into whose office I was summoned after failing my first bacteriology exam, right after my transfer from England. He took the time to read my exam, to realize that I had the answers to all the questions buried in the essay style of English university exams, and he taught me how to answer hour examinations in American. Not only has this greatly influenced my career, but it probably saved it in its embryonic stage.

I have been fortunate that there have been a number of this kind of teacher many, here at Harvard who have had faith in my ability. They have been able to offset the negative remarks from people who thought that I was too small; that a surgical residency was too tough for a woman; that I would never make it; and that it would be much better to go into some other field like anesthesia.

What has it been like? Perhaps I can paraphrase Dr. Culver who did not know what to call us. I was a girl medical student, a lady intern, a woman resident, a member of the fair sex chief resident; but finally, just a surgeon.



by Penelope K. Garrison '69

I am going to take another position and affirm that women are still different. I think that is attested to by the fact that we are all last on the program. Although Harvard is an enlightened institution, we have some distance to go before women are completely assimilated.

I am a pediatrician currently finishing my training in child psychiatry. My main interest is in child development and the variations in learning that individual children experience either because of neurological or cultural differences. The fact that I am a woman may or may not have determined the course my interest has followed since medical school; it probably did, because as a pediatric house officer I lost faith in my absolute infallibility. Who was I to advise mothers on the difficulties their children were having with development? I had received no training for this at HMS. I recognized that the mothers often had a kind of knowledge that I, as a physician, lacked. These children came to me from part of the community with which I was unacquainted. I recognized that I was ignorant and in pursuit of some

more useful knowledge, went on to train in child psychiatry. I chose a program that was community oriented in the ghetto area of the city so that I could directly observe children's behavior. I could also participate in cultural experiences unlike those I had been exposed to while traversing the straight and narrow path to becoming a physician.

I found myself in a situation where I was providing a service to families whose children were referred for psychiatric treatment because they misbehaved in school. Very often, the service was not requested either by the child or its parents but rather by the teacher. It was difficult to determine where the problem

originated. Was it a nasty teacher or an impossible child? I began visiting the schools and homes, only to find myself once more on unfamiliar ground. I had the privilege of being mistaken for a social worker, a teacher, etc. partly because I was a woman and did not look like a doctor. This was actually an advantage because people spoke more freely than they would have to a member of the medical profession who might be expected to be loyal to the established patterns of delivering care. I had a two-fold vantage point in the community — as a woman and a doctor. Instead of being viewed as omnipotent, and therefore supportive of the prevailing status quo, by being a woman I could achieve a closeness and rapport with those I wanted most to help.

In the last 25 years we have learned that women can work like men and, if they do, there will be similar opportunities at our disposal. Women's liberation will fall short if it simply liberates women to be like men, because we are different. The time has come for us to give up the task of proving that we can work just as hard as men, because we can; and of proving that we can do the things they can do, because we can. We must now become individuals, female individuals, who have different perspectives than men and who can make valid contributions as can all other minority group individuals. We are all colleagues, not competitors, in medicine.



Class Day 1974



Fending off the rain . . .

Class Day 1974 was almost a washout. The speakers gingerly tried to avoid the rain-soaked platform because the deafening downpour made the microphone an absolute necessity and a very real hazard; the audience kept its distance from the incessant rain by staying well within the tent's perimeter. But the Class Day program proceeded apace except that the traditional class recitation of the Oath of Hippocrates and the non-traditional Statement of Purpose were cancelled in deference to the inclement weather; both were re-printed on the program.

The Class of 1974 set a Harvard Medical School precedent in collating a Statement of Purpose, which they felt related more to the concerns of the physician in our multifarious society. The suggestion was made by the Class Day co-chairpersons, Howard H. Goldman and Margaret Strouse Ross, that each succeeding class continue to formulate such a statement. It was drafted originally by Lawrence Berger, then revised and adopted by a majority of the class. It reads:

The primary responsibility of the medical profession is to promote health and to prevent and relieve suffering:

—to provide care in the best humanistic and scientific tradition without regard to race, nationality, religion, sex, sexual preference, party politics, social standing or economic class;

—to practice medicine in the context of the needs of the individuals, their families, and the communities in which they live, above considerations of financial self-interest or personal prestige;

—to maintain concern for the quality of life, as well as for its preservation;

—to honor the rights of patients to considerate, respectful, and high quality care; to privacy and confidentiality; and to information about and participation in decisions regarding their health;

—to use medical knowledge in harmony with the laws of humanity and never for the purpose of torture, political oppression or genocide;

—to strive to eliminate the barriers to people's health; among them, poverty, racism, sexual discrimination, political oppression and war;

—to cooperate with other health workers and people in the community in providing medical care and promoting health;

—to consider the ethical, social, political, and economic consequences of medical decisions;

—to educate ourselves, our patients, and the public in matters of health;

—to advance knowledge into the causes of ill-health, their prevention and treatment, through conscientious and compassionate research;

—to fulfill our obligation not only as physicians, but as members of society.

We accept these responsibilities as consistent with the honored ideals of the medical profession, and as necessary in order to render service to humanity with full respect for the dignity of each person.

The prizes and awards for the Class of 1974 were announced by Dean of Students, Frederick C. Lane. The American Medical Women's Association presented four women graduates with citations: Eleanor Thomas Hobbs, Paula Dudnick Kushlan, Jane Wimpfeimer Newberger, and Amy Ann Pruitt.

Two students shared the Richard C. Cabot Prize "for a paper on medical education and history":
Amy Ann Pruitt — "Physicians in an Interdisciplinary Debate: Studies of Aphasia in the 19th Century"
James R. Snapper — "A History of the Pavilion Hospital"

Two students were also equal recipients of the Henry Asbury Christian Award "for diligence and notable scholarship":
Edward M. Crane — "The Synthesis of Prostaglandin $F_{2\alpha}$ by Human Endometrium in Organ Culture"
Michael Jean-Baptiste — "Studies on the Structure and Experimental Pathology of the Medical Nucleus of the Trapezoid Body in Cats"

Leon Reznick Memorial Prize "for excellence and accomplishment in research":
R. Michael Williams — "Studies on the Genetic Control of Histocompatible Tumor Resistance with Particular Emphasis on the Role of Specific Histocompatibility Linked Immune Response Genes"

Rose Seegal Prize "for scholarly contribution in the area of social and community medicine":
Philip Elkin — "The Relation of the Medical Profession to the Community: A Case Study — Yugoslavia"

James Tolbert Shipley Prize "for research, the results of which have been published or accepted for publication":
Harrison G. Pope, Jr. — two books, *Voices from the Drug Culture* and *The Road East*

Massachusetts Medical Society Award "to the medical student who seemed most notably to have developed the intangible qualities of The Good Physician": Charles A. Brown

Another departure from Class Day ceremonies of recent years was withholding the Harvard Medical Alumni Association award because there was no class president for the Class of 1974.

Prizes and awards for graduates from the Harvard School of Dental Medicine were announced by the Dean, Paul Goldhaber.

Harvard Dental Alumni Association's Gold Medal: Craig M. Inglis

Harvard Dental Alumni Association's Silver Medal: Nalton F. Ferraro

Dr. Norman B. Nesbitt Medal "for excellence in the field of dentistry":
Richard A. Hocevar

Harvard Odontological Society Award:
David J. Higginbotham

Dr. Grace Miliken Award "for the outstanding paper in the field of dental health": Dolores Franklin Suggs — "Tc-99m-polyphosphate Bone Imaging on Orthodontically Treated Dog Teeth"

Thirty-three members of the Class of 1974 were elected to membership in the national medical honorary, Alpha Omega Alpha. Three dental school graduates were elected to membership in the national dental honorary, Omicron Kappa Upsilon.

Because the 1974 Class Day program consisted of eight student speakers in addition to the faculty speaker, Dr. Lawrence Weed, professor, College of Medicine, University of Vermont, space does not permit us to print these speeches in this issue. Class Day papers will appear in a forthcoming *Bulletin* later this year.

Mother, father, David M. Rosenfeld '74, and child



Reunions

1924

HMS '24 held its 50th reunion in the form of a supper party given by the Eddy Caves and the Jim Faulkners at the Faulkners' house in Brookline. Twenty-nine members of the class showed up, most of them with their wives. In addition we had the delightful company of Dean and Mrs. Robert Ebert, of Gabriel Rubin's widow, Ann Rubin, and of course, Dorothy Murphy without whom no 50th would have been complete. The evening was made even more jolly by a case of champagne donated by the Alumni Association.

At the party Raymond J. Reitzel presented each classmate with an autographed bound copy of his autobiography which is indeed an interesting one. Ray had the good fortune to be born in a sod house on a prairie farm in South Dakota with wild Indians in the background and exposure to cyclones, prairie fires, and other environmental hazards. He saw interesting service in World War I as a YMCA secretary at

1924



1929

Our 45th anniversary of graduation from HMS was one of the most pleasant gatherings we ever have enjoyed. Twenty-three classmates, 20 spouses, and six guests gathered at the Copley Plaza in Boston. Classmates who came to the banquet included: H. Adams; J. Adams, Jr.; Arnold; Bright; Buddington; Dixon; Evans; Farrell; R. Gilman; Goodwin; Gundersen; Hill; Hurwitz;

prison camps in Siberia and Austria. He writes appreciatively of his teachers at the Harvard Medical School. In his later life he travelled to remote corners of the globe. All these experiences are well illustrated with photographs.

A surprise attendant at the reunion was Harry O. Veach of Rochester N.Y. who earned the first D.M.S. from the Harvard Medical School in 1924, working with Dr. Cannon. He later went to Cambridge University on a Moseley Traveling Fellowship and took his M.D. at Johns Hopkins in 1927. If we include a B.S. from Northwestern University in 1919 and an M.A. from Harvard University in 1922 he has probably collected the largest number of earned degrees of any member of the class.

All in all, it was a jolly and convivial evening. Many members of the class who had come from a distance expressed their particular appreciation of the all-day scientific program which took place on Thursday, May 30.

James M. Faulkner

Jacobson; Kelley; Maggio; Ortiz; Prien; Rhodes; Rosenberg; Serunian; Thompson; and Thorp.

The main speakers at the banquet were Langdon Parsons '27 and Perry J. Culver '41, who made a perfect combination. Dr. Parsons is one of the few men in Boston whom we remember as an instructor in surgery who still looks and behaves as he did 45 years ago. His stories were inimitable, and greatly

enjoyed by all. Dr. Culver, director of alumni relations, spoke in a more serious mood, assuring us that the students of today have changed radically from those involved in the rebellious times of the late 60s.

An opportunity for open discussions by our classmates after dinner brought out unsuspected talent and wisdom in men whom we thought we had known for 50 years. Bernie Jacobson, for example, gave an excellent and erudite talk on Israel with a very simple solution for the prompt settlement of what seems to be such a difficult problem. John Adams prodded the HMS administration for its procrastination in making plans for land obtained from the House of the Good Shepherd. Dave Hurwitz spoke on the theme, "Now is the time for decision." He pointed out that most of us have spent our lives in maintaining a compulsive drive for survival and for the education of our children. Now that some of these pressures are off, David reminded us that it might be wise to stop and think of different goals for us to seek while we are still young and healthy. Joe Evans commented briefly on medical problems in Colombia, S.A. At our next meeting, I do hope that the wives will have opportunities to address the assembly; many, I am sure, have excellent ideas. One, for example, assured me how happy she had been to exchange her former luxurious home for her present life in a trailer, and a small summer camp in New Hampshire. She now has a healthy, relaxed, talkative husband.

A noteworthy incident at the dinner was the selection by lot of a recipient of a beautiful oil painting of the waterfront at Thomaston, Maine, donated to our class by an anonymous benefactor. The winner of the painting was Dave Hurwitz, who is the father of a crew member of the vessel on which the donor and artist cruised the Antarctic.

We paid our respects to the 42 members who no longer are with us.

We broke up at a reasonable hour with enthusiastic plans for another reunion, not five years from now, but next year. Many favored the idea of another clam-bake like the one we had 20 years ago when Connie Hawes sat in the pouring rain enjoying his steamed clams.

Sylvester B. Kelley



1934

Our 40th reunion was well attended. On Alumni Day, some 44 classmates of the 109, with 37 wives (we are an all male class!) and one child attended. Half of the gathering were from Massachusetts, and they welcomed classmates from 13 other states — the Hopkins and Wilcoxes of California, the Freemans of Texas, the Dunlaps of Louisiana, the Heffners of Florida, and the Edwards and Wolfs of Missouri having made the longest trips. Everyone had received a copy of the very interesting red 40th reunion report, carefully compiled by Garrett Sullivan and the reunion office.

By Friday evening over 60 of us were enjoying the very attractive Stage Neck Inn at York Harbor, Maine. Due to the meticulous planning of reunion chairman Dick Thompson and his wife Barbara, no detail was overlooked. A delightful cocktail party preceded each meal, the food was delicious, the music well suited to our ears and years, and the dance floor constantly busy. Saturday morning was rainy, but a very interesting meeting was held, which filled the time until luncheon and clearing skies. The names of those who had died were read and greetings from far away members were noted — Australia, Hawaii, Rome, among others. It was reported that the class of 1934 has been most generous in its giving for its 40th — in total amount given, in per capita gift, and, most gratifying, in the per cent of the Class who contributed. This report will be published by the Fund Committee when their books are closed for 1973-1974. The highlight of the meeting was a talk, and question and answer period, with no holds barred, by our distinguished and widely travelled classmate David Rutstein.

The pleasant afternoon gave a chance to see the lovely town and shore of York Harbor. Saturday night featured a party; lobsters for dinner, toasts, music and dancing, and a huge 40th birthday cake. The surroundings were so pleasant and the group so congenial that everyone was most enthusiastic. On to our 45th!

Richard H. Thompson

1939

For the first time, our class held its reunion outside the Boston area, which had the advantage of better attendance by Boston area classmates who were not partly on call, and appearing and disappearing as in the past.



After the Friday morning activities and lunch on the Quad, we departed by bus, car, and ferry to the Harborside Inn in Edgartown on the lovely island of Martha's Vineyard. The weather was cool and rainy, but in some ways this helped. We sat around, put our feet up, and reminisced, renewed old friendships, and told gentle lies about our present and past accomplishments without large numbers of people dashing away to sail, play golf or tennis. At Saturday's dinner, our perennial presi-

dent Eben Alexander was in marvelous form; Franny Moore and Bill Moretz also held forth, as did Oie Ross, briefly.

Perhaps the highlight was a great underwater movie taken in the Sea of Cortez by Ted Rulison. There were spectacular shots of underwater activity, fish, hundreds of sharks, and beautiful scenes. The film apparently won an international prize for the best underwater movie by an amateur.

During the dinner, Walt Tucker reported on our questionnaire. The wives' questionnaire was a first and quite a success; I suspect that other classes may emulate this effort by my wife and her committee in future years.

The class of 1954 was also reuniting at Edgartown, and we decided that in general, we looked younger and in better shape. Unfortunately, we could not prove this as the weather prevented a challenge softball game! A handful of grown-up and most attractive children appeared briefly. Bill Hawley's daughter is about to enter medical school which two of her older brothers have already done. I think this is a record for our class. Among those who appeared at least once were the Alexanders, Balbonis, Braytons, Carletons, Conleys, Dyers, Gonzalez', Hawleys, Hayes',

1934

Kanes, Mahadys, McCorristons, Mixters, Moores, Moretz', Morrisons, Mostofis, Piers, The Paul Pierces, Rathbuns, Rikers, Ross', Rulesys, Rulisons, Stuppys, Tuckers, and Wighs. Lem Bowden, Dan Ellis, John Quinby, and John Stanbury made short solo appearances. A great time was had by all, and quite a few of us are convinced we should go to the same spot five years hence.

Frederick P. Ross



1944

The Class of '44 had a fine reunion from beginning to end. Twenty-eight classmates plus 27 wives attended the dinner at the Museum of Science on Thursday evening. We all had an excellent time; the cocktail party was well run and the food was good and served efficiently.

Fourteen classmates and wives, along with two children of one alumnus (making a grand total of 30), journeyed to the Lift Line Lodge at Stratton Mountain, Vermont for the weekend.

Initially, after we arrived and were in the midst of our first cocktail party, there was a question in the minds of some classmates as to why we had to come so far. By the time the affair was over this had been completely resolved. Everyone agreed that they had a wonderful time and that a resort hotel was the greatest idea they had ever heard of for a reunion.

A reunion such as this gives more time for relaxation, good talk, and good refreshment. I don't think it should be too structured, otherwise it becomes a busy

time with people feeling obligated to keep on the go in order to keep up with all the activities. Our activities were unstructured and everybody did what they wanted to, which made it more enjoyable. Actually, the only structured event was the cocktail party on Friday and again on Saturday evening to get people together prior to dinner. The food and service were good and we all enjoyed the provision of hors d'oeuvres for the cocktail party, which was unbelievable. We had a memorable, good time and those of us who attended are looking forward to the next reunion, five years hence.

Arthur W. Trott

1949

The Class of 1949 with the first women graduates of Harvard Medical School kicked off their reunion with cocktails and dinner at the Sonesta Hotel in Cambridge. Appropriate excerpts of the Aesculepian Show of 1949 were sung by Gus Swanson, Jim Jandle, Tim Oliver, and Dick Blanch in honor of Dr. Bert Dunphy, present as a member of the Alumni Council.

In recognition of the women in medicine, the Alumni Day presentations were moderated by classmate Raquel Cohen who provided not only a stimulating presentation of her own but a thoughtful discussion and introduction of the other papers.

The group departed from Hyannis by chartered ferry Friday afternoon for the White Elephant in Nantucket. Although the arrival was late the cocktail hour and dinner were advanced and a relaxed, wonderful evening was enjoyed by some ninety in all, including wives.

Rain on Saturday limited outdoor activity but provided a warm hospitable atmosphere in the hotel for renewing friendships. Following dinner in the evening, folk songs by Sam Clark with his guitar, excerpts of the tape-recorded '49 Aesculepian Show, and Del Boblitt's superb playing of the piano were culminated by a splash in the swimming pool led by John Keller at 2:00 a.m. All this made for a great evening. Lou Johnson travelled the greatest distance, coming from Germany just for the reunion. Edna Wojick's tremendous success at fund raising and the warmth and good time had by all should renew the class spirit and provide for the making of a great 30th reunion.

Charles L. Easterday

1954

After the Alumni Day Luncheon in the quadrangle on Friday, the Class of 1954 reconvened at the Harborside Inn at Edgartown on Martha's Vineyard. It was exciting to see so many familiar faces among the people and cars waiting for the 5:45 ferry at Woods Hole and still others already at the Inn when we arrived. Classmates, most with spouses and some with children, attending at least one reunion event included Allen (David), Alper, Austen, Binder, Bornstein, Bowen, Boyett, Breer, Briehl, Budil, Carey, Cattell, Couch, DePriest, Evans, Goldings, (both), Goldstein, Greenberg, Hitzrot, Ho, Jones, Judd, Kornfeld, Kramer, Letsov, Levine, Marcello, Marks, Martin, Matthews, O'Brien, Pincus, Poskanzer, Rubin, Schiebler, Senghas (both), Ship, Shore, Stein, Trieger, Tucker, and Vorenberg.

1944



It was an enjoyable weekend with conversation, relaxation and exploration not much diminished by the poor weather. The highlight came at the Class Dinner on Saturday evening with the opening of a gift to the Class sent from Iran by Farrokh Saidi. It was an absolutely beautiful Persian rug emblazoned with the coat of arms of the Harvard Medical School, a unique banner for a remarkable class.

The reunion broke up when the return ferry docked again at Woods Hole on Sunday afternoon with everyone pretty much talked out but looking forward to the 25th, to which everyone should come.

Thomas F. O'Brien

1949



1959

A small, but enthusiastic group of alumni and alumnae from the Class of 1959 convened for an evening of "dinner with a view" at the State Street Roof on Thursday evening; good fellowship and long waiting in line for food at Alumni Day on Friday; and a weekend of will-the-sun-come-out-or-won't-it at the Chatham Bars Inn on Cape Cod. The Burkhardts and Sandersons came all the way from Phoenix, and the Marks from Old Chatham, N.Y. to Chatham, Mass.

The members of the class collectively had obviously done very little research or practical study into the field of preventive gerontology; receding hairlines, strands of gray hair, and slightly larger paunches were visible on many (identifications shall remain anonymous).



tions along the way. The most unexpected news of all, however, was that the Colbergs did not buy any antiques while on the Cape.

Recalling the statement of the former Earl of Chesterfield that "Satan finds some mischief still for idle hands to do," the members of the class assembled in consort to design and create the official HMS 1959 flag, resplendent in white and crimson. The flag, to be used on future official functions of the class under the registered U.S. patent # HMS1959-74-15, is available on a rental basis for weddings, christenings, bar mitzvahs, and confirmations.

To conclude in a more serious vein, those of us present felt it was worth while and refreshing to renew old acquaintances and hope "to meet again for food and wine, in nineteen hundred and seventy-nine."

Robert S. Blacklow

Besides the exercise of going to and from the dining room for excellent cuisine and a Sunday afternoon clam-bake on the beach, a few hardy souls did engage in a tennis tournament without needing resuscitation from Jim Sidd, hernia repairs from Lucian Leape, or orthopedic help from Dick Conway or Bob Goldstone. Nor did Kim McCully or Dick Boden need to provide frozen sec-

1959



1964



1964

Members of the Class of '64 began to gather Friday morning at Alumni Day exercises. Despite beards, mustaches, and mod clothing, everyone was recognizable. There was a noticeable absence of paunch. Speeches, lunch, beer, and the class picture filled the early part of the day.

Sixty-five classmates and spouses met at the Holyoke Center penthouse for cocktails and dinner, in a room with a lovely view of Cambridge and the Charles. Everyone enjoyed the opportunity to renew friendships, exchange gossip and discuss the path(s) not taken. Honors for traveling the greatest distance go to T. Bennett (Saudi Arabia) and R. Northrup (Okinawa). Stateside, there were T. Vernon (Colorado), J. Tudor (Arkansas) and F. Williams (Florida).

The Saturday affair was something else again. One week before Class Day, the Cliff Hotel in Scituate burned down. This made Memorial Day weekend a nightmare of telephoning to find a new location and caterer, etc., etc. The clambake was held at the Warren Center in Holliston. While we were still reeling from the Fire Demon, the Rain Demons came to further dampen prospects for the affair. However, the Demons were exorcised successfully and a brave band gathered in the afternoon to complete the reunion.

Joseph K. Hurd, Jr.

1969

Only five years have gone by since the class of '69 graduated from HMS; about a third of the class still lives in the Boston area. This distance in both time and space can hardly generate sufficient nostalgia to motivate many to come to a reunion. And — as the reunion book attests — most class members are busy with the combined responsibilities of continuing medical training and raising young families. Consequently a small group gathered at Perry Culver's home in Lincoln on Saturday afternoon, June 1. Although rain forced most of the

party indoors, the group, its spirit undampened, enjoyed cocktails, an indoor barbecue, and conversation. There were almost as many children as adults, and the young ones kept the party lively. Classmates from the Boston area who attended were David Breyan, Ben Brooks, Mark Hallett, Mike Harrison, Ed Hoffer, Jon Kolb, Merrill Liteplo, Ken Rothman, George Thibault and Roland Ungerer. Brian Arling came up from Washington, D.C. and Randy Lewis and David Rottenberg from New York City. The reunion photograph catches Brian Arling, Royal Bartrum, Reginald Bauer, Mark Hallett, and Ken Rothman in an informal pose. Special thanks go to Dr. Culver and his wife for their enthusiasm, generosity, and hard work.

On Friday, as part of the Alumni Day program, Penny Garrison, a psychiatry fellow at McLean Hospital, spoke about her life as a female physician. She suggested that it was time to think beyond women's liberation and to note that women have different contributions to make to medicine than do men.

With five years to go until the next reunion, everyone expressed the hope that members of the class will continue to stay in touch during the intervening years.

Mark Hallett

1969



